

Dr. Brian H. Finn
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Scarsdale, NY 10583

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

NAME OF PATIENT

SIGNATURE OF PATIENT OR ADULT GUARDIAN

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
- A communication barrier prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Please specify)
